Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TX HEALTH DBA INJURY 1-DALLAS
9330 LBJ FREEWAY, SUITE 1000
DALLAS TX 75243

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-3004-01

MFDR Date Received
May 29, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please refer to the attached CCH D&O that should have resolved the extent of injury issues. Also, denied per EOB these are non-covered services because this is not deemed a medical necessity by the payer. CPT code 97799 CPCA was preauthorized, #069630701 therefore it is deemed medically necessary. "

Amount in Dispute: $8,750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier did not reimburse and shows on the EOB not a work related injury/illness and thus not the liability of the workers' compensation carrier. The requestor furnished a hearing officer decision and order arguing this supports their claim. The requestor is correct in stating that services were preauthorized; however, while the requested services may have been deemed medically necessary, the services were not for treatment of the compensable injury. The DWC found that the compensable injury did NOT extend to include a disc bulge at L2-L3, disc protrusions at L4-L5 or L5-S1, or L5 radiculopathy."

Response Submitted by: CHARTIS; 4100 Alpha Road, Suite 700; Dallas Texas 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 21, 23, 24, 27, 29, 2012 and March 2, 5, 2012	CPT code 97799-CP-CA x 8 hours x 7 days	$7,000.00	$7,000.00
February 22, 2012 and March 1, 2012	CPT code 97799-CP-CA x 7 hours x 2 days	$1,750.00	$1,750.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. Texas Labor Code 413.014, effective September 1, 2005, prohibits the insurance carrier from raising the issue of medical necessity on preauthorized treatment/services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 7, 14, 22, 23, 29, 2012 and April 12, 13, 19, 2012
   - 1 (191) – Not a work related injury/illness and thus not the liability of the workers' compensation carrier.
   - 1 – Unrelated to the compensable injury.

   Explanation of benefits dated March 16, 2012
   - 1 (50) – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
   - 1 – Payment for this charge is not recommended without a statement documenting medical necessity.

   Explanation of benefits dated March 19, 2012
   - 1 (216) – based on the findings of a review organization
   - 1 – unnecessary medical treatment and or service per peer review documentation

   Explanation of benefits dated April 3, 2012
   - 1 (214) – workers compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment
   - Service rendered does not relate to an accepted compensable injury or disease

Issues

1. Has the extent of injury issue been resolved?
2. Did the respondent support its '216' denial reason code?
3. Did the respondent support its '50' denial reason code?
4. Is the requestor entitled to reimbursement?

Findings

1. A Contested Case Hearing was held on November 30, 2011 to determine the extent of the compensable injury. The compensable injury is a lumbar sprain/strain. The hearing officer determined that the compensable injury does not extend to include a disc bulge at L2-L3, disc protrusion at L4-L5 or L5-S1, or L5 radiculopathy. The requestor billed with diagnosis code 847.2 – lumbar sprain. The denial reason codes "191" and "214" are not supported and the extent of injury issue has been resolved; therefore, the disputed services will be reviewed per applicable Division rules and fee guidelines.

2. The respondent denied the disputed services based on reason code "216 - Based on the findings of a review organization." The respondent did not include a copy of the peer review; therefore, this denial reason code is not supported and the disputed services will be reviewed per applicable Division rules and fee guidelines.

3. The respondent also denied the disputed services based on reason code "50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer." The respondent stated in its position summary that "The requestor is correct in stating that services were preauthorized". The requestor submitted an "Appeal of Adverse Determination" that states, "Having considered all information provided, we are now able to recommend the medical necessity for the above treatment/service as follows: preauthorization for 8 hours/day x 10 days for a total of 80 hours."

   Texas labor Code 413.014(e) states "If a specified health care treatment or service is preauthorized as provided by this section, that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service." Therefore, this denial reason code is not supported and the disputed services will be reviewed per applicable Division rules and fee guidelines.
4. The requestor is therefore entitled to reimbursement. 28 Texas Administrative Code §134.204(h)(1)(A) states "If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR." A review of the requestor's medical bill finds that the requestor used modifier "CA" with CPT code 97799.

   Texas Administrative Code §134.204(h)(5)(A) and (B) state "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs.

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the unit's column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $125.00 per hour.

The total allowable for the disputed services is as follows:

CPT 97799-CP-CA: $125.00 x 8 hours = $1000.00 x 7 days = $7,000.00

CPT 97799-CP-CA: $125.00 x 7 hours = $ 875.00 x 2 days = $1,750.00

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $8,750.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $8,750.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		August 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.